

Universal Health Insurance in the United States: Reflections on the Past, the Present, and the Future

We used to say that the United States shared with South Africa the distinction of being the only industrialized nation without universal health insurance. Now we don't even have South Africa to point to. Almost 20% of the nonelderly population in this country lacks health insurance at any given time, and the disparities in access to care and health outcomes are very much greater in the United States than anywhere else from which there are reasonable data.

It is relevant to the politics of health care that the high end of the American health care system compares favorably with that

anywhere in the world. Some significant fraction of all the total knee replacements in the world are performed in the United States. If you live in certain urban areas and you develop certain tumors, you will get the most sophisticated and advanced treatment anywhere in the world and have outcomes that are at least comparable to those anywhere. But there are considerable pockets of the population for whom access to health care and the effects on health status are much more similar to those of poorer and less successful Third World countries than they are to those

of the rest of the industrial world.

It is not as though these disparities are saving us any money: by any measure, we spend substantially more on health care than any other nation. Indeed, we spend more money on health care for Americans aged 65 years and older than is spent for the *entire* population of any other nation.

So the United States is by international standards quite peculiar, and the question is why. This is not just an academic question; to understand how to move effectively toward universal health care in the United

States, it is essential to understand how we got to where we are. Freud said that all psychiatric phenomena are overdetermined; that is, there are more explanations than you need to produce the outcome, and that is probably true of most of the social sciences as well. I have identified 10 explanations for why the United States is so peculiar, all of which are true—and any one of which by itself would probably be a sufficient explanation. These explanations fall into two broad categories: historical-cultural and structural-political.

HISTORICAL-CULTURAL EXPLANATIONS

1. Americans in general have more negative attitudes about government than people in most other countries, and certainly more negative than people in other democratic countries. This has been a consistent theme in American history since at least the 18th century. Several explanations have been given for this, starting with the self-selection of immigrants to the United States as far back as colonial times, when only the most adventurous or most desperate would brave the perils of the unknown. Draft dodging in European countries was a major source of immigration in the 19th century, and other waves of immigration followed failed efforts at political revolt and rebellion. There is also a religious dimension to this history, since many groups of immigrants defined themselves in opposition to established churches, or all hierarchical churches.

2. A variant of the first explanation is de Tocqueville's: the absence of a traditional aristocracy and the attendant social hierarchies in the New World

produced a culture much less accepting and respectful of authority, much more individualistic and independent, than existed anywhere else.

3. Although in fact socioeconomic status in the United States is at least as stratified as it is in other industrialized countries, in much of the rest of the world a large proportion of the population identifies itself as working class, or working people. In the United States, everyone self-identifies as middle class. This leads to a very simple syllogism about why the United States has no universal health insurance: there is no self-identified working class—no labor party, no national health insurance. It is hard to disconfirm that syllogism. But it leads to the fourth point.

4. Why had there never been a successful labor party in the United States? The answer certainly has something to do with the abundance of free or quasi-free land earlier in this nation's history, which meant that a substantially greater proportion of relatively low income working Americans owned real property than in most of the world. This abundance of land not only led to middle class self-identification but also permitted geographic mobility that made "exit" an alternative to "voice" among those with grievances toward the status quo.

5. The fifth historical-cultural explanation for the lack of universal health insurance in the United States is also an explanation for the lack of a labor party in the United States, that is, the persistent historical cleavage in the history of American politics—race. We never had a labor party because of our inability to bring Black and White workers together in a large-scale political movement.

POLITICAL-STRUCTURAL EXPLANATIONS

All 5 of the historical-cultural explanations for why universal health insurance has not come to the United States are, I think, accurate. But political-structural explanations are also important.

6. The most basic political-structural explanation is that James Madison was a really smart guy, and the constitution he designed largely accomplishes what he wanted: that is, within the confines of a basically democratic nation, policies that would redistribute significant resources from the wealthy to the more numerous poor and middle-income citizens are almost impossible to effect. The division of powers among branches of government, the differences between the Senate and the House of Representatives, and the role of an independent judiciary are all parts of this design, along with other constitutional features.

7. The Madisonian system built on, but can be distinguished from, the fundamentally centrifugal forces in American politics. The United States is a big, diverse country, without the religious, ethnic, or class identity on which national political movements can be built. In the United States, to an extent much greater than in any other democratic nation, all politics are local. And even with the greater national (and global) homogenization of culture driven by the mass media, we are becoming more heterogeneous politically and socially and in the character of the health care system.

8. As a result of these localistic tendencies and other aspects of the Madisonian system, the United States has some of the

world's weakest political parties. Only rarely does the content of a party's platform have much bearing on the health policies it follows once in office, and not since 1965 has the electoral success of one party produced a major shift in health policy—although a similar shift almost occurred in 1995 after another partisan triumph.

9. In the absence of strong parties, the power of money in politics becomes even greater. Individual politicians can succeed in the American political system without support of political party apparatuses, but (except for very rare exceptions) they can't succeed without great personal wealth or sizable contributions. At the same time, the government of the United States has always been a major generator of wealth—by building canals, or subsidizing the building of railroads, or purchasing munitions. So political contributions can often be evaluated in terms of simple return on investment. Groups with significant economic resources have long been opposed to universal health insurance.

10. We have a political system so sophisticated about finding the middle ground that we have had long periods in which the parties have been essentially even in their control of power in the national government. The president changes from one election to another without much difference in policy. This is not a new phenomenon in American history: our experience since 1972 mimics that of the period from 1876 to the end of the 19th century.

WHERE POLITICAL CHANGE COMES FROM

Having identified the major barriers to political change in the

United States, I now ask how any change ever occurs. Change does happen in the United States from time to time—in 1 of 3 ways. The first way is through “realigning elections.” Political scientists still debate the relative importance of the elections of 1928 and 1932 in ending a long period of Republican hegemony, but one or both of these elections led directly to the enactment of the Social Security Act in 1935. There is no doubt that the Lyndon B. Johnson landslide of 1964 produced Medicare and Medicaid in 1965.

Another realigning election in 1994 finished off the process begun by the election of 1980 in replacing a structural Democratic majority in Congress with a Republican one. Not all realigning elections run in the same direction, and not all facilitate expansions of government health programs. As a result of the 1994 elections, in 1995 to 1996 we came dangerously close to turning Medicaid into a block grant program and beginning an irreversible course of privatizing Medicare. The next major shifts could as likely go in one direction as another, and the strategy and tactics of advocates of universal health insurance need to take that into account.

The second way change comes about in the United States is as a result of the domestic fall-out of war. Many of the most positive changes that occurred in the health care system in the 1950s and 1960s had their origins in World War II programs. Social change comes much more rapidly during wartime than in peace. The problem is that this kind of sociopolitical change requires a real war, one that involves a very substantial mobilization of the population. Recent

experience suggests that U.S. elites may have discovered how to fight wars without mobilizing the public.

Once in a while, there is a third way that change happens in the United States. It is characterized by a major cultural shift that produces a rapid change in public policy. The most significant example in our time, perhaps the only one of this magnitude, involves public attitudes about, and policy toward, tobacco. In the span of a generation, a very widely consumed consumer product with a very significant economic role came to be broadly stigmatized, and public policy changed as a result. It was a rare and extraordinary set of events that gives one hope that very radical changes are possible.

STRATEGIC CONSIDERATIONS

Change is thus unlikely but not impossible. What is clear to me, based on the experiences of the last several decades, is that when the windows of opportunity for change present themselves, success will go to those ready and able to seize the opportunity to implement changes that they have been working toward and thinking about for a long time. It is going to happen someday, but it will be difficult for anyone to predict precisely when. So advocates had better be prepared. To that end, I would like to offer 4 strategic suggestions.

First, for the last 30 years the touchstone of reform has been the belief that we have to reallocate resources in the system in order to expand access to care. The American health care enterprise is already so large and so inefficient, the conventional wis-

dom has held, that simply rearranging it should be sufficient to make the problems of access largely go away. The problem with that syllogism is that it doesn't work: if you reduce expenditures for 1 part of the population, someone else pockets the money. In the political process, money is not entirely fungible. Furthermore, when you try to make the system more efficient, which it ought to be, this very act threatens to reduce the incomes and the perceived well-being of some people. They will resist such changes.

One of the 3 or 4 fatal flaws in the Clinton health reform effort was the president's commitment to come up with a plan for universal health insurance that wouldn't involve any new federal taxes. In principle, he believed, there was already enough money in the system. In principle, he was of course right, but the Rube Goldberg-like mechanisms required to get from here to there were so complex and so cumbersome and so incomprehensible that they brought the rest of the proposal down with them.

During the 1990s, there was an extraordinary increase in wealth in the United States, not just for the wealthiest 5% (although they were by far the largest gainers) but throughout the wealthiest half of the population. Many people are much richer than they were 10 years ago, but none of that growth has been directed to support health care for people without it. If advocates of reform keep trying to be prudent and efficient and reallocate money as a way of financing universal services, they are never going to succeed. We ought to accept that this is a wasteful and expensive country and just spend the money.

As a practical matter, you can reform the health care delivery system or you can reform health insurance, but you can't do both at the same time. The political task is just too onerous, and the policy implications are just too complicated. Experience in other countries is quite consistent with this principle, as has been the experience with Medicare in this country. There is a lot wrong with the health care system in addition to problems of access, but there is no logical reason why problems cannot be solved (or at least addressed) serially. When Medicare was enacted in 1965, its proponents were careful to minimize the changes it demanded of health care providers and indeed to defer to established practices, no matter how inefficient. Systems reform could, and did, come later. Medicare's proponents knew that the very process of extending coverage would begin to change the existing health system and create the impetus for still further changes. But in the short period of time provided by a fortuitous window of opportunity, only so many things can be accomplished at once. I do not believe that it is possible to achieve universal coverage at the same time as making real reform in the structure of the delivery system.

Second, advocates of universal health insurance need to remind not only themselves, but also their fellow citizens, of the moral and ethical roots of their position. For a host of complicated reasons, the growing infusion of religious and spiritual values into the political process in this country over the last generation has been primarily promoted by those religious groups opposed to progressive expansions of social benefits. Moral appeals play an

increasingly large role in the political process, but advocates of universal health insurance, whose own beliefs are generally grounded in a broad values framework and not just narrow self-interest, have been reluctant to join the fray on those terms.

For instance, universal health insurance advocates have neglected to seek coalition with religiously sponsored institutions, especially those associated with the Catholic church. Perhaps this reluctance stems from the observation that in much of the rest of the world, universal health insurance programs have been adopted over the fervent opposition of providers. But given the way the American political system protects entrenched interests, universal health insurance is never going to come to the United States without significant leadership on the part of the health care provider community itself. The Catholic Health Association represents one important provider group that should be approached by universal health insurance advocates.

Third, from the outside, it is distressing to observe how much of the discussion about universal health care consists of dialogue among those already committed. To continue the metaphor from the previous point, we are primarily preaching to the converted. And the conversation is taking place only in particular parts of the country—on the two coasts and in a few isolated Midwestern outposts in between. But the population of this country has been shifting southward and westward since the end of World War II. It has been shifting from areas where many people share the views of proponents of universal health insurance to areas where many people do not. Un-

less there are coalitions that have a widespread national reach, it is very hard to do anything. In fact, the problems of the uninsured and access to health care are more serious, by and large, in those communities where there is the least political sympathy for universal health insurance, suggesting precisely the appropriate targets for organizing and coalition building.

Finally, advocates of universal health insurance need to reject the proposition that their goals can be achieved through a series of incremental steps. When the concept of incrementalism first began appearing in the political science literature in the United States, the model was the Social Security Act, which began in 1935 in quite a limited form. The original law was confined to old-age benefits and Aid to Families with Dependent Children, but it didn't have survivor benefits, federal disability benefits, or much in the way of benefits for spouses, and of course didn't contain Medicare or Medicaid. In the 67 years the Social Security Act has been in existence, it has been amended 40 times, and most years the program has had some incremental improvement. Since the founding fathers of Medicare and Medicaid were primarily alumni of the Social Security system's development, it is not surprising that they adopted a similar strategy toward health insurance.

But somehow, over time, this particularistic strategy has been transformed into a normative imperative about how to do politics in the United States. According to this view, the only possible change is incremental: expanding health insurance can only be achieved in incremental steps. But over the last 35 years, incre-

mental expansions in public health insurance have not been sufficient to reduce the number of the uninsured. The private health insurance system has been unraveling at a pace roughly equal to that of expansions in public programs, while population growth has largely been driven by immigration—immigration to a country in which a widely disproportionate share of new Americans lack health insurance.

Meanwhile, as proponents of universal health insurance have been incrementally trudging “sideways,” advocates of nonincremental strategies in other spheres of politics and public policy have scored some notable successes, at least from their point of view. For instance, in the mid-1990s the Economic Opportunity Act was repealed, along with many other valuable remnants of the Great Society's legislative outburst of 1965 to 1966. Major parts of the infrastructure through which civil rights were enforced in the 1970s and 1980s have been dismantled. In 1995 to 1996, Congress eliminated entitlement for cash benefits for low-income mothers and their children, along with a whole range of entitlements for legal immigrants. In addition, Congress came very close to eliminating the entitlement status of Medicaid. There have been very significant nonincremental changes in other areas of public policy as well.

Those who worked most strenuously for all those changes had no patience for incrementalism as a prescriptive theory: they always felt that it was a much better strategy to go for broke. They asked for too much, they overreached, on the theory that you are only going to get a fraction of what you ask for anyway, but if

you don't ask for enough to start with, you certainly won't get enough.

This is an old political debate, but whatever the advocates of universal health insurance have been doing for the last 30 or 35 years, it obviously hasn't worked very well. There is very little to lose from trying something different. One of the different things that might be tried is to determine in very broad terms what the goals and principles of universal health insurance are by deciding on a set of defining ethical and moral principles and insisting that those goals and objectives be part of every conversation until they are achieved. Perhaps the “Rekindling Reform” initiative will help shape such goals and principles for universal health insurance. ■

Bruce Vladeck, PhD

About the Author

The author is with the Mount Sinai Medical Center, New York City.

Requests for reprints should be sent to Bruce Vladeck, PhD, Box 1062, Mount Sinai Medical Center, New York, NY 10029 (e-mail: bruce.vladeck@msnyuhealth.org).

This editorial was accepted September 9, 2002.